NHSGGC *FORMULARY* APPEALS PROCESS

The *Formulary* appeals procedure has recently been reviewed and updated. Within NHSGGC, the ADTC decides whether to add a product to the *Formulary* based on the SMC decision and local circumstances as shown below.

SMC decision	Glasgow ADTC decision
'Unique drug' accepted for use within NHS Scotland.	Added to the *Formulary*.
Accepted for use within NHS Scotland.	Local decision based on existing *Formulary* choices, usually involving local specialist opinion. Restrictions to use may be applied.
Accepted for restricted use within NHS Scotland.	Local decision based on existing *Formulary* choices, usually involving local specialist opinion. SMC restrictions will be applied, additional restrictions may be imposed.
Not recommended for use within NHS Scotland.	Not added to the *Formulary*.

Appeals can be made to the ADTC if an SMC-accepted drug has not been added to the *Formulary* and it is thought that such an omission could compromise patient care. Appeals can be made to the ADTC's Formulary and New Drugs Sub-committee by any consultant, GP, senior pharmacist or senior nurse.

The person completing the appeal documentation should provide supporting information including:

- **Why the drug should be added to the *Formulary***
- **Details of target patient group**
- **Therapeutic benefits**
- **Place in therapy**
- **Advantages over existing *Formulary* choices.**

Successful appeals will be publicised through the ADTC decisions table in *PostScript*; this edition highlights positive appeals for fosamprenavir, ivabradine and telmisartan.

Pharmaceutical industry personnel cannot appeal decisions to the ADTC. Medicines not approved by the SMC will not be added to the *Formulary* and no appeals can be made to the ADTC. The manufacturer can make a resubmission to the SMC.

Following Scottish Executive Guidance, NHSGGC has developed a register which requires all employees engaged in relevant committees or decision-making to declare any interests in the pharmaceutical industry.

Anyone working in NHSGGC wishing to obtain appeal documentation or more detailed information on the *Formulary* processes should view the *Formulary* pages on the intranet at **staffnet/Info+Centre/GGC+Formulary/default.htm**

PostScRipt
from the
NHSGGC Area Drug & Therapeutics Committee
Issue 42 November 2007

In this issue . . .

Website
http://www.ggcformulary.scot.nhs.uk

New treatment for opioid dependence

Buprenorphine/naloxone (Suboxone®) has been accepted by the SMC for restricted use for substitution treatment for opioid drug dependence, within a framework of medical, social and psychological treatment. It is restricted to patients for whom methadone is not suitable. It has been added to the NHSGGC Total *Formulary,* restricted to initiation by specialist addiction services. Methadone 1mg/ml is the Formulary Preferred List choice.

Buprenorphine is a partial opioid receptor agonist. Suboxone contains buprenorphine and naloxone in a ratio of 4:1. When administered sublingually, it acts in the same way as buprenorphine alone since naloxone is inactive sublingually. If injected, the naloxone becomes active and precipitates withdrawal in opioid-dependent patients. This is an established strategy for reducing the potential for intravenous misuse and reduces the risks of diversion and illicit use where dosing is not supervised.

Trials comparing buprenorphine/naloxone, buprenorphine and placebo demonstrated that buprenorphine/naloxone had similar effectiveness to buprenorphine alone and both were significantly more effective than placebo. The incidence of adverse events with buprenorphine/naloxone was comparable to buprenorphine monotherapy.

In 2006, NICE carried out a systematic review and economic evaluation of methadone and buprenorphine for the management of opioid dependence. Flexible dosing of methadone gave a statistically significant superior retention in treatment compared with flexible dosing of buprenorphine (Risk Ratio [RR] 1.20; 95% confidence interval [CI] 1.07, 1.33). There was no significant difference in the level of opiate abuse. When comparable fixed doses of methadone and buprenorphine were considered, methadone was more effective than buprenorphine for retention in treatment, although at low doses the two drugs were comparable

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For all article references, check our website
http://www.ggcformulary.scot.nhs.uk

Alphabetical list of most recent ADTC decisions

For full details of SMC advice, visit **www.scottishmedicines.org** For NICE advice, visit **www.nice.org.uk** For previous ADTC decisions, visit **www.ggcformulary.scot.nhs.uk**

Drug	Indication under consideration (There may be other licensed indications)	Glasgow decision	
Abatacept (Orencia®)	Moderate to severe active rheumatoid arthritis in adult patients who have had an insufficient response or intolerance to other disease-modifying anti-rheumatic drugs including at least one tumour necrosis factor inhibitor. To be used in combination with methotrexate.	Non-*Formulary*.	X
Beclometasone dipropionate (Clipper®)	Mild to moderate ulcerative colitis in active phase as add-on therapy to 5-ASA containing drugs.	Non-*Formulary* for this formulation and indication.	X
Betaine (Cystadane®)	Homocystinuria (adjunctive treatment).	Non-*Formulary*.	X
Budesonide (Budenofalk®)	Active ulcerative colitis limited to the rectum and the sigmoid colon.	Non-*Formulary*.	X
Celecoxib (Celebrex®)	Ankylosing spondylitis.	Non-*Formulary* for this indication.	X
Ertapenem (Invanz®)	Prophylaxis of surgical site infection following elective colorectal surgery in adults.	Non-*Formulary* for this indication.	X
Escitalopram (Cipralex®)	Obsessive compulsive disorder.	Non-*Formulary*.	X
Fosamprenavir (Telzir®) (ADTC appeal)	HIV infection.	*Formulary* (Total *Formulary*). Restricted to use by HIV specialists.	✓R
Ivabradine (Procoralan®) (ADTC appeal)	Chronic stable angina.	*Formulary* (Total *Formulary*). Restricted to specialist initiation for the symptomatic treatment of chronic stable angina pectoris in patients with normal sinus rhythm for whom heart rate control is desirable and who have a contra-indication or intolerance for beta-blockers and rate-limiting calcium-channel blockers.	✓R
Levetiracetam (Keppra®)	Adjunctive therapy in the treatment of partial onset seizures with or without secondary generalisation in children from 4 years of age with epilepsy.	Non-*Formulary* for this indication.	X
Levetiracetam (Keppra®)	Adjunctive therapy in the treatment of myoclonic seizures in adults and adolescents from 12 years of age with juvenile myoclonic epilepsy.	Non-*Formulary* for this indication.	X
Levetiracetam (Keppra®)	Adjunctive therapy in the treatment of primary generalised tonic-clonic seizures in adults and adolescents from 12 years of age with generalised idiopathic epilepsy.	Non-*Formulary* for this indication.	X
Levetiracetam (Keppra®)	Monotherapy in the treatment of partial onset seizures with or without secondary generalisation in patients from 16 years of age with newly diagnosed epilepsy.	Non-*Formulary* for this indication.	X
Pioglitazone (Actos®)	Combination with insulin in type 2 diabetes mellitus patients with insufficient glycaemic control on insulin for whom metformin is inappropriate because of contraindications or intolerance.	*Formulary* (Preferred List). Acknowledge new indication. Restricted to specialist initiation.	✓R
Risperidone (Risperdal Quicklet®)	Treatment of acute and chronic schizophrenia and similar psychosis, treatment of mania in bipolar disorder.	*Formulary* (Total *Formulary*). Acknowledge new formulation. Restricted to use in patients with swallowing difficulties.	✓R
Sitagliptin (Januvia®)	Type 2 diabetes mellitus to improve glycaemic control in combination with metformin (when diet, exercise and metformin alone are insufficient).	*Formulary* (Total *Formulary*). Restricted to specialist initiation for patients only when the addition of sulphonylureas is not appropriate.	✓R
Sodium oxybate (Xyrem®)	Cataplexy in adult patients with narcolepsy.	Non-*Formulary*.	X
Tacrolimus modified release (Advagraf®)	Prophylaxis of transplant rejection in adult kidney or liver allograft recipients and treatment of allograft rejection resistant to treatment with other immunosuppressive medicinal products in adult patients.	*Formulary* (Total *Formulary*). Acknowledge new formulation. Restricted to specialist use.	✓R
Telmisartan (Micardis®) (ADTC appeal)	Hypertension.	*Formulary* (Total *Formulary*). Restricted to second line use in patients with hypertension with a significant cough on an ACE inhibitor. Excludes combination products.	✓R
Testosterone (Intrinsa®)	Hypoactive sexual desire disorder in bilaterally oophorectomised and hysterectomised (surgically induced menopause) women receiving concomitant oestrogen therapy.	Non-*Formulary* for this indication.	X
Ziconotide (Prialt®)	Severe, chronic pain in patients who require intrathecal analgesia.	Non-*Formulary*.	X

✓= *Formulary* ✓R = *Formulary* (restricted) **x** = non-*Formulary* **?** = awaiting final decision

Fentanyl patches

Opioids contained in the NHSGGC *Formulary* Preferred List include morphine, oxycodone and diamorphine. Fentanyl patches are on the Total *Formulary,* restricted to use on specialist advice in palliative care and to second line use in patients with intractable, non-malignant pain which is relatively stable and has been controlled by oral therapy. It should be reserved for patients with swallowing difficulties or who have problems with opioid constipation. The Primary Care Palliative Care Team has prepared guidance on appropriate use of this drug. For more information see 'Facts about Fentanyl' at **www.palliativecareglasgow.info** or contact a specialist in palliative care, your local hospice or palliative care pharmacist.

Initiating therapy

Transdermal fentanyl may be considered only for patients with stable pain. This is because it takes 6-12 hours for the patch to begin to work and 36-48 hours to reach stable plasma levels. The dose should not be increased before 72 hours have passed, and any dose increase will take 48 hours to achieve full therapeutic effect.

Fentanyl is a strong opioid, 100-150 times more potent than oral morphine, and extreme care must be taken if starting patches in strong opioid-naïve patients.

Approximate dose conversion ranges based on morphine use are available on our website, in the fentanyl product literature (**www.medicines.org.uk**) and the BNF. Each strength of fentanyl patch can be considered approximately equivalent to a very wide range in doses of oral morphine. Although the SPC suggests starting with the 25micrograms/hour preparation, consider using the 12micrograms/hour preparation (off-label) in, for example, frail elderly patients who had received a strong opioid at a low dose in the past.

As for all strong opioids that are pure agonists, there is theoretically no maximum ceiling dose of transdermal fentanyl but practical issues, such as number of patches and body surface available, may dictate how high the dose can go above 300 micrograms/hour.

At the end of life, or if previously controlled pain becomes unstable or acute, the patch should be continued and supplemented with either immediate release oral or sub-cutaneous strong opioid. Contact a specialist to discuss dosage and methodology.

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New treatment for opioid dependence *contd from page 1*

(RR 1.10; 95% CI 0.66, 1.54). There are no published trials comparing methadone and buprenorphine/naloxone.

The decision on whether to use methadone or buprenorphine to treat opioid dependence should take into account the person's history of opioid dependence, their commitment to a particular strategy and the risks and benefits of each treatment. If both drugs are equally suitable, methadone should be prescribed first line. Methadone should be administered daily, under supervision. Supervision should be relaxed only when compliance is assured. In Glasgow, historically high rates of supervision have been very successful in reducing the amount of drug diverted on to the street.

SUMMARY

• Buprenorphine/naloxone (Suboxone®) has been accepted by the SMC for restricted use.
• It has been added to the NHSGGC Total *Formulary* restricted to initiation by specialist addiction services. Methadone 1mg/ml is the Preferred List choice.
• Buprenorphine/naloxone has similar efficacy and safety to buprenorphine alone.
• Flexible dosing of methadone provides superior retention on treatment than buprenorphine.
• Any NHSGGC healthcare professional who wishes further information should contact Glasgow Addiction Services on 0141 276 6600.

Fentanyl patches *contd from page 3*

SUMMARY

• Fentanyl may be a suitable option in palliative care or for patients with intractable, non-malignant pain.
• Use only for stable chronic pain, not acute/unstable pain.
• Option for patients when oral route not viable, eg poor absorption or swallowing difficulties.
• Option for patients when morphine or other oral strong opioids cause continual intolerable side effects, eg confusion, excessive drowsiness, constipation.
• Option for patients with poor compliance with treatment which may be assisted by a supervised patch change.
• Take great care when initiating therapy as fentanyl is a strong opioid 100-150 times more potent than oral morphine.
• Take care when transferring patient from oral morphine to transdermal fentanyl as there is a very wide range in equivalency.
• Patches are now available in a new matrix formulation (Durogesic DTrans®/Matrifen®) and the older gel-reservoir formulation (generic). Ensure patient receives the intended formulation and avoid switching between formulations to avoid patient confusion. Only the matrix form is available in the 12 micrograms/hour strength.

NHSGGC *Formulary* 1st edition: corrections

The following medicines were omitted unintentionally from the first printed edition of the NHSGGC *Formulary*. These medicines remain on the Total *Formulary* with existing restrictions and will be included in future printed editions.
• Co-amilofruse (restricted to patients with compliance problems who require loop diuretic plus potassium sparing diuretic)
• Trazodone
• Quetiapine (restricted to psychiatrist initiation).

Webwatch

Continuing our recent theme of websites which provide reference sources, clinicians looking for quick answers to clinical questions should consider Clinical Answers (**www.clinicalanswers.nhs.uk/**), ATTRACT (**www.attract.wales.nhs.uk/**) or the TRIP database (**www.tripdatabase.com/**).

Clinical Answers is a pilot project run by the National Library for Health. The service is limited but will expand over the course of the project and is a pragmatic attempt to answer questions in a clinically relevant timeframe. ATTRACT was created in response to a needs assessment exercise carried out in Wales. Clinicians were keen to practice evidence-based medicine, but did not have the time and/or expertise to keep up to date. The TRIP database is a searchable database of evidence-based medicine queries, medical images and patient information leaflets. Twenty-seven specialist search engines, with additional content, are being introduced on topics from allergy to urology.

Unfortunately ATTRACT will only accept questions from practitioners in Welsh general practice and Clinical Answers is currently only funded to answer questions from NHS England. However, they are useful resources for quick answers to common questions. Some examples of questions on the sites are shown below:
• What training is recommended for nurses for spirometry reading and interpretation?
• Can taking thyroxine tablets in the evening instead of the morning cause insomnia?
• Why are benzodiazepines addictive when other sedative psychotropics, such as phenothiazines or atypical antipsychotics, are not?
• Where can I find a patient information leaflet which explains when you need a sick note, when you need to be 'signed back on', how to self certify?
• Is there any evidence that statins can increase the incidence of Parkinson's disease?
• Is there any data on long term outcomes, particularly mortality, in type 2 diabetics treated with sulphonylureas or insulin? I believe there is some such data for metformin.
• Is there evidence for using ambulatory BP monitoring in general practice? How does this compare with patients performing their own BPs on electronic machines? Which electronic machines are best?

NHS Greater Glasgow and Clyde

Area Drug & Therapeutics Committee
Chair: Dr J Fox

Communications Sub-group
Chair: Mrs A Thompson

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PostScript Editor: Mrs A Thompson
Prescribing Team, NHS Greater Glasgow & Clyde
Pharmacy & Prescribing Support Unit
Queen's Park House, Victoria Infirmary, Langside Road
Glasgow G42 9TY Tel: 0141 201 5214 Fax: 0141 201 5338
E-mail: audrey.thompson@nhs.net

PostScript Web editor: Dr A Power

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Suboxone

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